



Recommended Screening Tools

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Scoring and Interpreting the EPDS

Instructions for Use:

1. The mother is asked to check the response that comes closest to how she has been feeling **in the previous 7 days**.
2. All the items must be completed.
3. Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers should come from the mother or pregnant woman.)
4. The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

Scoring:

Questions 1, 2, & 4 (without an *) are scored 0, 1, 2 or 3 with the top box scored as 0 and the bottom box scored as 3.

Questions 3, 5-10 (marked with an *) are reverse scored, with the top box scored as 3 and the bottom box scored as 0.

Maximum score: 30

Possibly depressed: 13 or greater

Always look at item 10 (*thoughts of self-harm/suicide*)

Edinburgh Postnatal Depression Scale¹ (EPDS)

Name: _____

Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____

Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:

- Yes, all the time
- Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
- No, not very often Please complete the other questions in the same way.
- No, not at all

In the past 7 days:

- | | |
|---|--|
| <p>1. I have been able to laugh and see the funny side of things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I always could <input type="checkbox"/> Not quite so much now <input type="checkbox"/> Definitely not so much now <input type="checkbox"/> Not at all | <p>*6. Things have been getting on top of me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time I haven't been able to cope at all <input type="checkbox"/> Yes, sometimes I haven't been coping as well as usual <input type="checkbox"/> No, most of the time I have coped quite well <input type="checkbox"/> No, I have been coping as well as ever |
| <p>2. I have looked forward with enjoyment to things</p> <ul style="list-style-type: none"> <input type="checkbox"/> As much as I ever did <input type="checkbox"/> Rather less than I used to <input type="checkbox"/> Definitely less than I used to <input type="checkbox"/> Hardly at all | <p>*7. I have been so unhappy that I have had difficulty sleeping</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>*3. I have blamed myself unnecessarily when things went wrong</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, some of the time <input type="checkbox"/> Not very often <input type="checkbox"/> No, never | <p>*8. I have felt sad or miserable</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Not very often <input type="checkbox"/> No, not at all |
| <p>4. I have been anxious or worried for no good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> No, not at all <input type="checkbox"/> Hardly ever <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> Yes, very often | <p>*9. I have been so unhappy that I have been crying</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, most of the time <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Only occasionally <input type="checkbox"/> No, never |
| <p>*5. I have felt scared or panicky for no very good reason</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite a lot <input type="checkbox"/> Yes, sometimes <input type="checkbox"/> No, not much <input type="checkbox"/> No, not at all | <p>*10. The thought of harming myself has occurred to me</p> <ul style="list-style-type: none"> <input type="checkbox"/> Yes, quite often <input type="checkbox"/> Sometimes <input type="checkbox"/> Hardly ever <input type="checkbox"/> Never |

Administered/Reviewed by _____ Date _____

¹Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

²Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

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Edinburgh Postnatal Depression Scale
Translation – Spanish
 Escala de Edimburgo para la depresión postparto

Name: _____ Date: _____

Si está embarazada: número de semanas de embarazo: _____

Si se encuentra en la etapa de postparto: número de semanas de postparto: _____

Como va a tener un bebé (o acaba de tener un bebé) nos gustaría saber cómo se ha estado sintiendo. Marque la respuesta que más se acerca a cómo se ha sentido en los últimos 7 días, no solamente cómo se siente hoy. En el ejemplo que se encuentra a continuación, la "X" significa "Me he sentido contenta casi siempre durante la última semana".

EJEMPLO: Me he sentido contenta:

- Sí, siempre
 Sí, casi siempre
 No muy a menudo
 No, nunca

Complete las siguientes preguntas de la misma manera.

En los últimos 7 días:

1. He podido reír y ver el lado bueno de las cosas:

- Tanto como siempre
 No tanto ahora
 Mucho menos
 No, no he podido

2. He mirado al futuro con placer:

- Tanto como siempre
 Algo menos de lo que solía hacer
 Definitivamente menos
 No, nada

3. Me he culpado sin necesidad cuando las cosas marchaban mal:

- Sí, casi siempre
 Sí, algunas veces
 No muy a menudo
 No, nunca

4. He estado ansiosa y preocupada sin motivo:

- No, nada
 Casi nada
 Sí, a veces
 Sí, a menudo

5. He sentido miedo o pánico sin motivo alguno:

- Sí, bastante
 Sí, a veces
 No, no mucho
 No, nada

6. Las cosas me oprimen o agobian:

- Sí, casi siempre
 Sí, a veces
 No, casi nunca
 No, nada

7. Me he sentido tan infeliz, que he tenido dificultad para dormir:

- Sí, casi siempre
 Sí, a menudo
 No muy a menudo
 No, nada

8. Me he sentido triste o desgraciada:

- Sí, casi siempre
 Sí, bastante a menudo
 No muy a menudo
 No, nada

9. He estado tan infeliz que he estado llorando:

- Sí, casi siempre
 Sí, bastante a menudo
 Solo ocasionalmente
 No, nunca

10. He pensado en hacerme daño a mi misma:

- Sí, bastante a menudo
 Sí, a menudo
 Casi nunca
 No, nunca

**Edinburgh Postnatal Depression Scale
Translation – Portuguese
Escala de Depressão Pós-Natal de Edimburgo**

Name: _____ Date: _____

Se estiver grávida: De quantas semanas está grávida? _____

Se estiver em período pós-parto: Há quantas semanas se encontra em período pós-parto? _____

Se estiver para ter bebé (ou se teve um bebé recentemente), gostaríamos de saber como se sente. Agradecemos que assinale a resposta que melhor indique o modo como se tem sentido nestes últimos 7 dias e não apenas como se sente hoje. No exemplo abaixo, o “X” significa, “Senti-me feliz quase sempre durante a semana passada.”

EXEMPLO: Senti-me feliz

- Sim, sempre
 Sim, quase sempre
 Não, poucas vezes
 Nunca

Queira responder às perguntas abaixo do mesmo modo.

Nos últimos 7 dias:

1. Tenho sido capaz de me rir e de ver o lado divertido das coisas

- Tanto como antes
 Não tanto como antes
 Definitivamente muito menos do que antes
 Nunca

2. Tenho vindo a aguardar pelo futuro com optimismo

- Tanto como sempre
 Bastante menos do que costumava
 Definitivamente muito menos do que costumava
 Quase nunca

3. Tenho-me culpado sem necessidade quando as coisas correm mal

- Sim, a maioria das vezes
 Sim, algumas vezes
 Raramente
 Nunca

4. Tenho estado ansiosa ou preocupada sem motivo

- Não, nunca
 Quase nunca
 Sim, por vezes
 Sim, muitas vezes

5. Tenho-me sentido com medo ou apavorada sem grande motivo

- Sim, muitas vezes
 Sim, por vezes
 Raramente
 Nunca

6. Tenho-me sentido oprimida sem poder resolver as coisas do dia-a-dia

- Sim, a maioria das vezes não tenho conseguido resolvê-las
 Sim, por vezes não tenho conseguido resolvê-las como normalmente
 Não, a maioria das vezes resolvo-as facilmente
 Não, resolvo-as tão bem como antes

7. Tenho-me sentido tão infeliz que tenho dificuldade em dormir

- Sim, a maioria das vezes
 Sim, por vezes
 Raramente
 Nunca

8. Tenho-me sentido triste ou muito infeliz

- Sim, a maioria das vezes
 Sim, frequentemente
 Raramente
 Nunca

9. Tenho-me sentido tão infeliz que choro

- Sim, a maioria das vezes
 Sim, frequentemente
 Apenas ocasionalmente
 Nunca

10. Tive ideias de fazer mal a mim mesma

- Sim, muitas vezes
 Por vezes
 Muito raramente
 Nunca

Scoring and Interpreting the PHQ-9

The patient is asked to respond to each of the 9 items based on how they've been feeling **over the last 2 weeks**. The total score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. PHQ-9 total score for the nine items ranges from 0 to 27. In the perinatal period, a score of ≥ 10 indicates possible depression.

The final question asks the patients to report – *"how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?"* This single patient-rated difficulty item is not used in calculating any PHQ-9 score or diagnosis but rather represents the patient's global impression of symptom-related impairment. It may be useful in decisions regarding initiation of or adjustments to treatment since it is strongly associated with both psychiatric symptom severity as well as multiple measures of impairment and health-related quality of life.

Maximum score: 27

Possibly depressed: 10 or greater

Always look at item 9 (*thoughts of self-harm/suicide*)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult
at all

Somewhat
difficult

Very
difficult

Extremely
difficult

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las <u>últimas 2 semanas</u> , ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? (Marque con un "□" para indicar su respuesta)	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a) o sin esperanzas	0	1	2	3
3. Ha tenido dificultad para quedarse o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Sin apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en ciertas actividades, tales como leer el periódico o ver la televisión	0	1	2	3
8. ¿Se ha movido o hablado tan lento que otras personas podrían haberlo notado? o lo contrario – muy inquieto(a) o agitado(a) que ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que estaría mejor muerto(a) o de lastimarse de alguna manera	0	1	2	3

FOR OFFICE CODING 0 + + +

=Total Score:

Si marcó cualquiera de los problemas, ¿qué tanta dificultad le han dado estos problemas para hacer su trabajo, encargarse de las tareas del hogar, o llevarse bien con otras personas?

No ha sido difícil

Un poco difícil

Muy difícil

Extremadamente difícil

QUESTIONÁRIO SOBRE A SAÚDE DO/A PACIENTE- (PHQ-9)

Durante as últimas 2 semanas, com que frequência você foi incomodado/a por qualquer um dos problemas abaixo?

(Marque sua resposta com "✓")

	Nenhuma vez	Vários dias	Mais da metade dos dias	Quase todos os dias
1. Pouco interesse ou pouco prazer em fazer as coisas	0	1	2	3
2. Se sentir "para baixo", deprimido/a ou sem perspectiva	0	1	2	3
3. Dificuldade para pegar no sono ou permanecer dormindo, ou dormir mais do que de costume	0	1	2	3
4. Se sentir cansado/a ou com pouca energia	0	1	2	3
5. Falta de apetite ou comendo demais	0	1	2	3
6. Se sentir mal consigo mesmo/a — ou achar que você é um fracasso ou que decepcionou sua família ou você mesmo/a	0	1	2	3
7. Dificuldade para se concentrar nas coisas, como ler o jornal ou ver televisão	0	1	2	3
8. Lentidão para se movimentar ou falar, a ponto das outras pessoas perceberem? Ou o oposto – estar tão agitado/a ou irrequieto/a que você fica andando de um lado para o outro muito mais do que de costume	0	1	2	3
9. Pensar em se ferir de alguma maneira ou que seria melhor estar morto/a	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Se você assinalou qualquer um dos problemas, indique o grau de dificuldade que os mesmos lhe causaram para realizar seu trabalho, tomar conta das coisas em casa ou para se relacionar com as pessoas?

Nenhuma
dificuldade

Alguma
dificuldade

Muita
dificuldade

Extrema
dificuldade

Scoring and Interpreting the GAD-7

The patient is asked to respond to each of the 7 items based on how they've been feeling **over the last 2 weeks**. The total score is calculated by assigning scores of 0, 1, 2, and 3, to the response categories of "not at all," "several days," "more than half the days," and "nearly every day," respectively. GAD-7 total score for the seven items ranges from 0 to 21. Though designed primarily as a screening and severity measure for generalized anxiety disorder, the GAD-7 also has moderately good operating characteristics for three other common anxiety disorders – panic disorder, social anxiety disorder, and post-traumatic stress disorder. In the perinatal period, a score of ≥ 7 indicates possible anxiety.

Maximum score: 21

Possible anxiety: 7 or greater

Spitzer RL, Kroenke K, Williams JBW, Löwe B. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med* 2006;166:1092-1097.

Zhong Q-Y, Gelaye B, Zaslavsky AM, et al. Diagnostic Validity of the Generalized Anxiety Disorder - 7 (GAD-7) among Pregnant Women. *PLoS ONE*. 2015;10(4):1-17. doi:10.1371/journal.pone.0125096.

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

GAD-7

Durante las <u>últimas 2 semanas</u> , ¿qué tan seguido ha tenido molestias debido a los siguientes problemas? <i>(Marque con un " " para indicar su respuesta)</i>	Ningún día	Varios días	Más de la mitad de los días	Casi todos los días
1. Se ha sentido nervioso(a), ansioso(a) o con los nervios de punta	0	1	2	3
2. No ha sido capaz de parar o controlar su preocupación	0	1	2	3
3. Se ha preocupado demasiado por motivos diferentes	0	1	2	3
4. Ha tenido dificultad para relajarse	0	1	2	3
5. Se ha sentido tan inquieto(a) que no ha podido quedarse quieto(a)	0	1	2	3
6. Se ha molestado o irritado fácilmente	0	1	2	3
7. Ha tenido miedo de que algo terrible fuera a pasar	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

Elaborado por los doctores Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke y colegas, mediante una subvención educativa otorgada por Pfizer Inc. No se requiere permiso para reproducir, traducir, presentar o distribuir.

GAD-7

Durante as últimas 2 semanas, com que frequência você foi incomodado/a pelos problemas abaixo?

Nenhuma vez

Vários dias

Mais da metade dos dias

Quase todos os dias

(Marque sua resposta com "✓")

1. Sentir-se nervoso/a, ansioso/a ou muito tenso/a	0	1	2	3
2. Não ser capaz de impedir ou de controlar as preocupações	0	1	2	3
3. Preocupar-se muito com diversas coisas	0	1	2	3
4. Dificuldade para relaxar	0	1	2	3
5. Ficar tão agitado/a que se torna difícil permanecer sentado/a	0	1	2	3
6. Ficar facilmente aborrecido/a ou irritado/a	0	1	2	3
7. Sentir medo como se algo horrível fosse acontecer	0	1	2	3

(For office coding: Total Score T_____ = _____ + _____ + _____)

Scoring and Interpreting the AUDIT-C

The AUDIT-C is a 3-item alcohol screen that can help identify persons who are hazardous drinkers or have active alcohol use disorders (including alcohol abuse or dependence). The AUDIT-C is a modified version of the 10 question AUDIT instrument. The 3 questions can be self-administered via pen and paper, or administered via clinician interview.

The AUDIT-C is scored on a scale of 0-12. Each AUDIT-C question has 5 answer choices. Points allotted are:

a = 0 points, b = 1 point, c = 2 points, d = 3 points, e = 4 points

In perinatal women, a score of 3 or more is considered positive, optimal for identifying hazardous drinking or active alcohol use disorders. ***However, when the points are all from Question #1 alone (#2 and #3 are zero), it can be assumed that the patient is drinking below recommended limits and it is suggested that the provider review the patient's alcohol intake over the few months immediately prior to learning of pregnancy, to confirm accuracy.*** Generally, the higher the score, the more likely it is that the patient's drinking is affecting his or her safety.

Maximum score: 12

Possible alcohol misuse: 3 or greater

AUDIT-C Questionnaire

Name: _____

Date: _____

These questions refer to the last 12 months:

1. How often do you have a drink containing alcohol?

- a. Never
- b. Monthly or less
- c. 2-4 times a month
- d. 2-3 times a week
- e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

- a. 1 or 2
- b. 3 or 4
- c. 5 or 6
- d. 7 to 9
- e. 10 or more

3. How often do you have six or more drinks on one occasion?

- a. Never
- b. Less than monthly
- c. Monthly
- d. Weekly
- e. Daily or almost daily

Cuestionario AUDIT-C

Nombre: _____

Fecha: _____

Estas preguntas se refieren a los últimos 12 meses:

1. ¿Con qué frecuencia consume alguna bebida alcohólica?

- a. Nunca
- b. Una o menos veces al mes
- c. De 2 a 4 veces al mes
- d. De 2 a 3 más veces a la semana
- e. 4 o más veces a la semana

2. ¿Cuántas consumiciones de bebidas alcohólicas suele realizar en un día de consumo normal?

- a. 1 o 2
- b. 3 o 4
- c. 5 o 6
- d. 7, 8 o 9
- e. 10 o más

3. ¿Con qué frecuencia toma 6 o más bebidas alcohólicas en un solo día?

- a. Nunca
- b. Menos de una vez al mes
- c. Mensualmente
- d. Semanalmente
- e. A diario o casi a diario

Scoring and Interpreting the DAST-10

The DAST-10 is a 10-item, yes/no, self-report instrument that has been shortened from the 28-item DAST and should take less than 5 minutes to complete. The DAST-10 was designed to provide a brief instrument for clinical screening and treatment evaluation and can be used with adults and older youth. The answer options for each item are “YES” or “NO”.

When the term “drug abuse” is used, it refers to the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g. LSD) or narcotics (e.g., heroin. Remember that the questions do not include alcohol or tobacco.

For the DAST-10, total score is calculated by adding 1 point for each question answered “YES”, except for question (3) for which a “NO” answer receives 1 point and a “YES” answer receives 0. In perinatal women, a score of ≥ 1 or greater indicates risk of substance misuse and should be further assessed.

Maximum score: 10

Possible substance misuse: 1 or greater

Skinner, H.A. (1982) The Drug Abuse Screening Test. *Addictive Behavior*, 7(4), 363-371.

Lam LP, Leung WC, Ip P, et al. (2015) Validation of the Drug Abuse Screening Test (DAST-10): A study on illicit drug use among Chinese pregnant women. *Scientific Reports*, 5(1). doi:10.1038/srep11420.

DAST-10 Questionnaire

Name: _____

Date: _____

The following questions concern information about your potential involvement with drugs other than alcohol and tobacco ***during the past 12 months***. Carefully read each question and decide if your answer is "Yes" or "No." Then circle the number under the appropriate column.

When the term "drug abuse" is used, it means the use of prescribed or over-the-counter medications/drugs in excess of the directions and any non-medical use of drugs. The various classes of drugs may include: cannabis (e.g., marijuana, hash), solvents, tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g. LSD) or narcotics (e.g., heroin. Remember that the questions do not include alcohol or tobacco.

If you have difficulty with a statement, then choose the response that is mostly right. You may choose to answer or not answer any of the questions in the section.

These questions refer to the last 12 months.	No	Yes
1. Have you ever used drugs other than those required for medical reasons?	0	1
2. Do you abuse more than one drug at a time?	0	1
3. Are you always able to stop using drugs when you want to? (If never use drugs, answer "Yes.")	1	0
4. Have you had "blackouts" or "flashbacks" as a result of drug use?	0	1
5. Do you feel bad or guilty about your drug use? (If never use drugs, choose "No.")		
6. Does your spouse (or parents) ever complain about your involvement with drugs?	0	1
7. Have you neglected your family because of your use of drugs?	0	1
8. Have you engaged in illegal activities in order to obtain drugs?	0	1
9. Have you experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	0	1
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.?)	0	1

Name: _____

Date: _____

CUESTIONARIO DE USO DE DROGAS (DAST-10)

Las siguientes preguntas se refieren a información acerca de su potencial involucramiento con drogas **excluyendo alcohol y tabaco** durante los últimos 12 meses. Lea con cuidado cada pregunta y decida si su respuesta es “No” o “Si”. Después, marque el casillero apropiado junto a la pregunta.

Cuando la palabra “abuso de drogas” es usada, esta se refiere al uso de medicinas compradas con receta medica o sin ella y que son ingeridas en exceso de lo recomendado. Las varias clases de drogas pueden incluir: cannabis (mariguana, hashis), solventes, tranquilizantes (Valium), barbitúricos, cocaína, estimulantes (speed), alucinógenos (LSD) o narcóticos (heroína). Recuerde que las preguntas **no incluyen** alcohol o tabaco.

Por favor responda cada pregunta. Si tiene dificultades con alguna de las preguntas, escoja la que le parezca correcta.

Estas Preguntas Están Referidas a los Últimos Doce Meses:	No	Si
1. ¿Ha usado drogas que no eran requeridas por razones medicas?	<input type="checkbox"/>	<input type="checkbox"/>
2. ¿Ud. abusa mas de una droga a la vez?	<input type="checkbox"/>	<input type="checkbox"/>
3. ¿Es Ud. capaz de parar de usar drogas siempre cuando se lo propone?	<input type="checkbox"/>	<input type="checkbox"/>
4. ¿Ha tenido "perdidas de conocimiento" o una "memoria repentina" como resultado del uso de drogas?	<input type="checkbox"/>	<input type="checkbox"/>
5. ¿Alguna vez se siente mal o culpable debido a su uso de drogas?	<input type="checkbox"/>	<input type="checkbox"/>
6. ¿Alguna vez su pareja (o familiares) se han quejado de su uso de drogas?	<input type="checkbox"/>	<input type="checkbox"/>
7. ¿Ha desatendido a su familia debido a su uso de drogas?	<input type="checkbox"/>	<input type="checkbox"/>
8. ¿Se ha implicado en actividades ilegales con el fin de obtener drogas?	<input type="checkbox"/>	<input type="checkbox"/>
9. ¿Alguna vez ha experimentado síntomas de abstinencia (sentirse enfermo) cuando dejo de usar drogas?	<input type="checkbox"/>	<input type="checkbox"/>
10. ¿Ha tenido problemas médicos como resultado de su uso de drogas (perdida de la memoria, hepatitis, convulsiones, hemorragia, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>

Instructions for Using the NIDA Quick Screen

The NIDA Quick Screen is a one-question preliminary screen that will sometimes prompt administration of the NIDA-Modified ASSIST, in cases where substance use is indicated and further assessment is required. The NIDA Quick Screen asks about past year use of alcohol, tobacco, prescription and illicit drug use. You may deliver it as an interview and record patient responses, or read the questions aloud and have the patient fill out responses on a written questionnaire.

If the patient says "**Never**" for all drugs in Quick Screen, reinforce abstinence. For example, you may say "It is really good to hear you aren't using drugs. That is a very smart health choice." **Screening is complete.**

If patient answers indicate **one or more days of heavy drinking**, patient is an *at-risk drinker* and further assessment should follow (i.e. administration of AUDIT-C or another validated alcohol screening tool).

If the patient says "**Yes**" for **use of illegal or prescription drugs for nonmedical reasons**, begin the NIDA-Modified ASSIST.

Scoring and Interpreting the NIDA-Modified ASSIST

The NIDA-Modified ASSIST is an 8-question screening tool that assesses the patient's level of risk related to use of illicit and prescription drugs (e.g. cannabis, cocaine, prescription stimulants, methamphetamine, inhalants, sedatives, hallucinogens, street opioids, and prescription opioids). Patients may fill in the ASSIST form themselves, or it can be completed via interview.

For each substance, add up the scores received for Questions 2–7. This is the Substance Involvement (SI) score. Do not include the results from either Step 1 (Quick Screen), Question 1 or Question 8 in your SI score. The patient will receive an SI score for *each* substance endorsed, not a cumulative score. Therefore, the patient's risk level may differ from drug to drug.

Use the resultant SI score to identify patient's risk level. If more than one substance is reported, focus intervention on the substance with the highest score. *For perinatal women, a score of ≥ 4 is considered a positive screen.*

Maximum score: 27

Possible substance abuse: 4 or greater

NIDA Quick Screen V1.0¹

Name: Sex () F () M Age.....

Interviewer..... Date/...../.....

Introduction (Please read to patient)

Hi, I'm _____, nice to meet you. If it's okay with you, I'd like to ask you a few questions that will help me give you better medical care. The questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances we'll talk about are prescribed by a doctor (like pain medications). But I will only record those if you have taken them for reasons or in doses other than prescribed. I'll also ask you about illicit or illegal drug use—but only to better diagnose and treat you.

Instructions: For each substance, mark in the appropriate column. For example, if the patient has used cocaine monthly in the past year, put a mark in the “Monthly” column in the “illegal drug” row.

NIDA Quick Screen Question:	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
<u>In the past year, how often have you used the following?</u>					
Alcohol					
<ul style="list-style-type: none"> • For men, 5 or more drinks a day • For women, 4 or more drinks a day 					
Tobacco Products					
Prescription Drugs for Non-Medical Reasons					
Illegal Drugs					

- If the patient says “**NO**” for all drugs in the Quick Screen, reinforce abstinence. **Screening is complete.**
- If the patient says “**Yes**” to **one or more days of heavy drinking**, *patient is an at-risk drinker*. Please see NIAAA website “How to Help Patients Who Drink Too Much: A Clinical Approach” http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm, for information to **Assess, Advise, Assist, and Arrange** help for at risk drinkers or patients with alcohol use disorders
- If patient says “**Yes**” to **use of tobacco**: Any current tobacco use places a patient at risk. Advise *all tobacco users to quit*. For more information on smoking cessation, please see “Helping Smokers Quit: A Guide for Clinicians” <http://www.ahrq.gov/clinic/tobacco/clnhlpsmksqt.htm>
- If the patient says “**Yes**” to **use of illegal drugs or prescription drugs for non-medical reasons**, proceed to **Question 1** of the NIDA-Modified ASSIST.

¹ This guide is designed to assist clinicians serving adult patients in screening for drug use. The NIDA Quick Screen was adapted from the single-question screen for drug use in primary care by Saitz et al. (available at <http://archinte.ama-assn.org/cgi/reprint/170/13/1155>) and the National Institute on Alcohol Abuse and Alcoholism’s screening question on heavy drinking days (available at http://pubs.niaaa.nih.gov/publications/Practitioner/CliniciansGuide2005/clinicians_guide.htm). The NIDA-modified ASSIST was adapted from the World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), Version 3.0, developed and published by WHO (available at http://www.who.int/substance_abuse/activities/assist_v3_english.pdf).

Questions 1-8 of the NIDA-Modified ASSIST V2.0

Instructions: Patients may fill in the following form themselves but screening personnel should offer to read the questions aloud in a private setting and complete the form for the patient. To preserve confidentiality, a protective sheet should be placed on top of the questionnaire so it will not be seen by other patients after it is completed but before it is filed in the medical record.

Question 1 of 8, NIDA-Modified ASSIST	Yes	No
<p>In your <i>LIFETIME</i>, which of the following substances have you ever used?</p> <p><i>*Note for Physicians: For prescription medications, please report nonmedical use only.</i></p>		
a. Cannabis (marijuana, pot, grass, hash, etc.)		
b. Cocaine (coke, crack, etc.)		
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)		
d. Methamphetamine (speed, crystal meth, ice, etc.)		
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)		
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)		
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)		
h. Street opioids (heroin, opium, etc.)		
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)		
j. Other – specify:		

- Given the patient’s response to the Quick Screen, the patient *should not indicate “NO”* for all drugs in Question 1. If they do, remind them that their answers to the Quick Screen indicated they used an illegal or prescription drug for nonmedical reasons within the past year and then **repeat Question 1**. If the patient indicates that the drug used is not listed, please mark ‘Yes’ next to ‘Other’ and continue to **Question 2** of the NIDA-Modified ASSIST.
- If the patient says “Yes” to any of the drugs, proceed to **Question 2** of the NIDA-Modified ASSIST.

Question 2 of 8, NIDA-Modified ASSIST					
2. <u>In the past three months</u> , how often have you used the substances you mentioned (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
• Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
• Cocaine (coke, crack, etc.)	0	2	3	4	6
• Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	2	3	4	6
• Methamphetamine (speed, crystal meth, ice, etc.)	0	2	3	4	6
• Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	2	3	4	6
• Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	2	3	4	6
• Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	2	3	4	6
• Street opioids (heroin, opium, etc.)	0	2	3	4	6
• Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	2	3	4	6
• Other – Specify:	0	2	3	4	6

- For patients who report “Never” having used any drug in the past 3 months: **Go to Questions 6-8.**
- For any recent illicit or nonmedical prescription drug use, go to **Question 3.**

3. <u>In the past 3 months</u> , how often have you had a strong desire or urge to use (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
b. Cocaine (coke, crack, etc.)	0	3	4	5	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	4	5	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	4	5	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	4	5	6
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	3	4	5	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	4	5	6
h. Street Opioids (heroin, opium, etc.)	0	3	4	5	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	4	5	6
j. Other – Specify:	0	3	4	5	6

4. <u>During the past 3 months</u> , how often has your use of (first drug, second drug, etc) led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
b. Cocaine (coke, crack, etc.)	0	4	5	6	7
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	4	5	6	7
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	4	5	6	7
e. Inhalants (nitrous oxide, glue, gas, pain thinner, etc.)	0	4	5	6	7
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	4	5	6	7
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	4	5	6	7
h. Street opioids (heroin, opium, etc.)	0	4	5	6	7
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	4	5	6	7
j. Other – Specify:	0	4	5	6	7

5. <u>During the past 3 months</u> , how often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
b. Cocaine (coke, crack, etc.)	0	5	6	7	8
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	5	6	7	8
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	5	6	7	8
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	5	6	7	8
f. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	0	5	6	7	8
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	5	6	7	8
h. Street Opioids (heroin, opium, etc.)	0	5	6	7	8
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	5	6	7	8
j. Other – Specify:	0	5	6	7	8

Instructions: Ask Questions 6 & 7 for all substances ever used (i.e., those endorsed in the Question 1).

6. Has a friend or relative or anyone else <u>ever</u> expressed concern about your use of (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

7. Have you ever tried and failed to control, cut down or stop using (first drug, second drug, etc)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
a. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	6
b. Cocaine (coke, crack, etc.)	0	3	6
c. Prescribed Amphetamine type stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	0	3	6
d. Methamphetamine (speed, crystal meth, ice, etc.)	0	3	6
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	0	3	6
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	0	3	6
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	0	3	6
h. Street opioids (heroin, opium, etc.)	0	3	6
i. Prescribed opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	0	3	6
j. Other – Specify:	0	3	6

Instructions: Ask Question 8 if the patient endorses any drug that might be injected, including those that might be listed in the other category (e.g., steroids). Circle appropriate response.

8. Have you ever used any drug by injection (NONMEDICAL USE ONLY)?	No, never	Yes, but not in the past 3 months	Yes, in the past 3 months
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- Recommend to patients reporting any prior or current intravenous drug use that they get tested for HIV and Hepatitis B/C.
- If patient reports using a drug by injection in the past three months, ask about their pattern of injecting during this period to determine their risk levels and the best course of intervention.
 - If patient responds that they inject once weekly or less OR fewer than 3 days in a row, provide a brief intervention including a discussions of the risks associated with injecting.
 - If patient responds that they inject more than once per week OR 3 or more days in a row, refer for further assessment.

Note: Recommend to patients reporting any current use of alcohol or illicit drugs that they get tested for HIV and other sexually transmitted diseases.

Tally Sheet for scoring the full NIDA-Modified ASSIST:

Instructions: For each substance (labeled a–j), add up the scores received for questions 2-7 above. This is the Substance Involvement (SI) score. Do not include the results from either the Q1 or Q8 (above) in your SI scores.

Substance Involvement Score	Total (SI SCORE)
a. Cannabis (marijuana, pot, grass, hash, etc.)	
b. Cocaine (coke, crack, etc.)	
c. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	
d. Methamphetamine (speed, crystal meth, ice, etc.)	
e. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	
f. Sedatives or sleeping pills (Valium, Serepax, Xanax, Ativan, Librium, Rohypnol, GHB, etc.)	
g. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	
h. Street Opioids (heroin, opium, etc.)	
i. Prescription opioids (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.)	
j. Other – Specify:	

Use the resultant Substance Involvement (SI) Score to identify patient’s risk level.

To determine patient’s risk level based on his or her SI score, see the table below:

Level of risk associated with different Substance Involvement Score ranges for Illicit or nonmedical prescription drug use	
0-3	Lower Risk
4-26	Moderate Risk
27+	High Risk

Instructions for Using the 4Ps

The 4Ps is a screening device often used as a way to begin a discussion about drug and alcohol use. The 4Ps is comprised of 4 “YES/NO” questions regarding the patient’s **P**ast, **P**resent, **P**arents, and **P**artner. The 4Ps can be administered via clinician interview or self-administered via pen and paper.

Any "YES" should be used to trigger further discussion about drug or alcohol use. Any woman who answers "YES" to 2 or more questions should be considered for referral for further assessment.

RECOMMENDATION: All pregnant women should be educated on the dangers of substance use during pregnancy and screened for substance use disorder and alcohol use, particularly during the first and third trimesters. The American College of Obstetricians and Gynecologists (ACOG) recommends universal screening with brief intervention and treatment referrals for cannabinoids, alcohol, dissociative drugs, hallucinogens, opioids, stimulants, tobacco and other compounds such as anabolic steroids and inhalants.

The 4Ps Screening for Substance Use

Please answer the following questions by checking the box next to "Yes" or "No."

1. Have you ever used drugs or alcohol during this Pregnancy?

- Yes
- No

2 Have you had a problem with drugs or alcohol in the Past?

- Yes
- No

3 Does your Partner have a problem with drugs or alcohol?

- Yes
- No

4 Do you consider one of your Parents to be an addict or alcoholic?

- Yes
- No